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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval South Carolina Medicaid State Plan Amendment (SPA) 19-0004-A

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice of Hearing: Reconsideration of Disapproval.

SUMMARY: This notice announces an administrative hearing to be held on January 12, 2022, at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909 to reconsider CMS' decision to disapprove South Carolina's Medicaid SPA 19-0004-A.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by **[insert date 15 days after publication in the Federal Register].**

FOR FURTHER INFORMATION CONTACT:

Benjamin R. Cohen, Presiding Officer
CMS
7500 Security Blvd
MS B1-01-31
Baltimore MD 21244-1850
Telephone: (410) 786-3169

SUPPLEMENTARY INFORMATION:

This notice announces an administrative hearing to reconsider CMS's decision to disapprove South Carolina's Medicaid state plan amendment (SPA) 19-0004-A, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 28, 2019 and disapproved on May 21, 2021. This SPA requested CMS approval to update annual supplemental teaching physician (STP) payment program using the Average Commercial Rate (ACR) methodology

effective April 1, 2019. This SPA included Greenville Memorial Hospital, and Palmetto Health, Richland/USC.

The issues to be considered at the hearing are whether South Carolina SPA 19-0004-A is inconsistent with the requirements of:

- Section 1902(a)(2) of the Social Security Act (the Act), providing that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act, providing that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.

- Section 1903(w)(1)(A)(i)(I) of the Act, providing that, notwithstanding the previous provisions of section 1903, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to section 1903(w)) shall be reduced, inter alia, by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year from provider-related donations other than bona fide provider-related donations, as defined in section 1903(w)(2)(B).

- Section 1903(w)(2)(A) of the Act, providing that, in section 1903(w), except as provided

in section 1903(w)(6), the term "provider-related donation" means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by— (i) a health care provider (as defined in section 1903(w)(7)(B)), (ii) an entity related to a health care provider (as defined in section 1903(w)(7)(C)), or (iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of section 1903(a).

- Section 1903(w)(2)(B) of the Act, providing that, for purposes of section 1903(w)(1)(A)(i)(I), the term "bona fide provider-related donation" means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

- Section 1903(w)(6)(A) of the Act, providing that, notwithstanding the provisions of section 1903(w), the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under title XIX, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903.

- 42 C.F.R. § 433.54(b), (c)(2), and (c)(3), providing that provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in 42 C.F.R. § 433.54(c). A hold harmless practice exists if, inter alia, all or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation; or if the State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).

Section 1116 of the Act and federal regulations at 42 CFR Part 430 establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a state plan or plan amendment. CMS is required to publish in the Federal Register a copy of the notice to a state Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If we subsequently notify the state Medicaid agency of additional issues that will be considered at the hearing, we will also publish that notice in the Federal Register.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as *amicus curiae* must petition the presiding

officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to South Carolina announcing an administrative hearing to reconsider the disapproval of its SPAs reads as follows:

Robert M. Kerr

Director

South Carolina Department of Health and Human Services

Post Office Box 8206

Columbia, SC 29202-8206

Dear Mr. Kerr:

I am responding to the July 19, 2021 request for reconsideration of the decision to disapprove South Carolina's State Plan amendment (SPA) 19-0004-A. South Carolina SPA 19-0004-A was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 28, 2019 and disapproved on May 21, 2021. I am scheduling a hearing on the request for reconsideration to be held on January 12, 2022, at the Department of Health and Human Services, Division of Medicaid Field Operations, South, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations, 61 Forsyth St., Suite 4T20, Atlanta, Georgia 30303-8909.

I am designating Mr. Benjamin R. Cohen as the presiding officer. If these arrangements present any problems, please contact Mr. Cohen at (410) 786-3169. In order to facilitate any communication that may be necessary between the parties prior to the hearing, please notify the

presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing. If the hearing date is not acceptable, Mr. Cohen can set another date mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by federal regulations at 42 CFR Part 430.

This SPA requested CMS approval to update annual supplemental teaching physician (STP) payment program using the Average Commercial Rate (ACR) methodology effective April 1, 2019. This SPA included Greenville Memorial Hospital, and Palmetto Health Richland/USC.

The issues to be considered at the hearing are whether South Carolina SPA 19-0004-A is inconsistent with the requirements of:

- Section 1902(a)(2) of the Social Security Act (the Act), providing that the state plan must assure adequate funding for the non-federal share of expenditures from state or local sources, such that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.

- Sections 1903(a) and 1905(b) of the Act, providing that states receive a statutorily determined Federal Medicaid Assistance Percentage (FMAP) for allowable state expenditures on medical assistance.

- Section 1903(w)(1)(A)(i)(I) of the Act, providing that, notwithstanding the previous provisions of section 1903, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State

plan (as determined without regard to section 1903(w)) shall be reduced, inter alia, by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year from provider-related donations other than bona fide provider-related donations, as defined in section 1903(w)(2)(B).

- Section 1903(w)(2)(A) of the Act, providing that, in section 1903(w), except as provided in section 1903(w)(6), the term "provider-related donation" means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by— (i) a health care provider (as defined in section 1903(w)(7)(B)), (ii) an entity related to a health care provider (as defined in section 1903(w)(7)(C)), or (iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of section 1903(a).

- Section 1903(w)(2)(B) of the Act, providing that, for purposes of section 1903(w)(1)(A)(i)(I), the term "bona fide provider-related donation" means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

- Section 1903(w)(6)(A) of the Act, providing that, notwithstanding the provisions of section 1903(w), the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching

hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under title XIX, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903.

- 42 C.F.R. § 433.54(b), (c)(2), and (c)(3), providing that provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in 42 C.F.R. § 433.54(c). A hold harmless practice exists if, inter alia, all or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation; or if the State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).

In the event that CMS and the State come to agreement on resolution of the issues which formed the basis for disapproval, these SPAs may be moved to approval prior to the scheduled hearing.

Sincerely,

Chiquita Brooks-LaSure
Administrator

cc: Benjamin R. Cohen

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Evell J. Barco Holland, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Section 1116 of the Social Security Act (42 U.S.C. section 1316; 42 CFR section 430.18) (Catalog of Federal Domestic Assistance Program No. 13.714. Medicaid Assistance Program.)

Dated: November 26, 2021.

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Evell J. Barco Holland,

Federal Register Liaison,

Centers for Medicare & Medicaid Services.

[FR Doc. 2021-26136 Filed: 11/30/2021 8:45 am; Publication Date: 12/1/2021]